

Wright (J.)

A Cyst of the Nasopharynx
and a Cyst of the Oropharynx.

BY

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A CYST OF THE NASOPHARYNX AND A CYST OF THE OROPHARYNX.*

By JONATHAN WRIGHT, M. D.

IT is now ten years since Tornwaldt published a paper in which he claimed that sinuses in the naso-pharyngeal mucous membrane were very frequently the seat of chronic inflammation and the origin of the symptoms of postnasal catarrh; that the "pharyngeal bursa" is a normal structure in the nasopharynx; that naso-pharyngeal cysts are very common. Great credit is due to Tornwaldt for drawing attention to these conditions, but his work has unfortunately fallen into discredit because of its inaccuracy.

In the first place sinuses in the naso-pharyngeal mucous membrane are not very common, while naso-pharyngeal cysts are very rare. In the next place, there are a great many cases of naso-pharyngeal catarrh which have for their lesion neither cysts nor sinuses. Lastly the "pharyngeal bursa" has been shown to be probably not a normal anatomical structure, but the result of chronic inflammation.

I need only remind the members of this association that the explanation of the formation of this "bursa" and of these cysts and sinuses, when they do occur, is that the folds and projections of the mucous membrane in the nasopharynx of infancy and adolescence become agglutinated at their edges or on contiguous sides, thus forming sinuses or closed cavities which in the first case is favorable to the production and discharge of thick muco-pus, and in the second case to its retention, dilating the walled-in space to the proportions of a cyst.

* Read before the American Laryngological Association at its seventeenth annual congress.



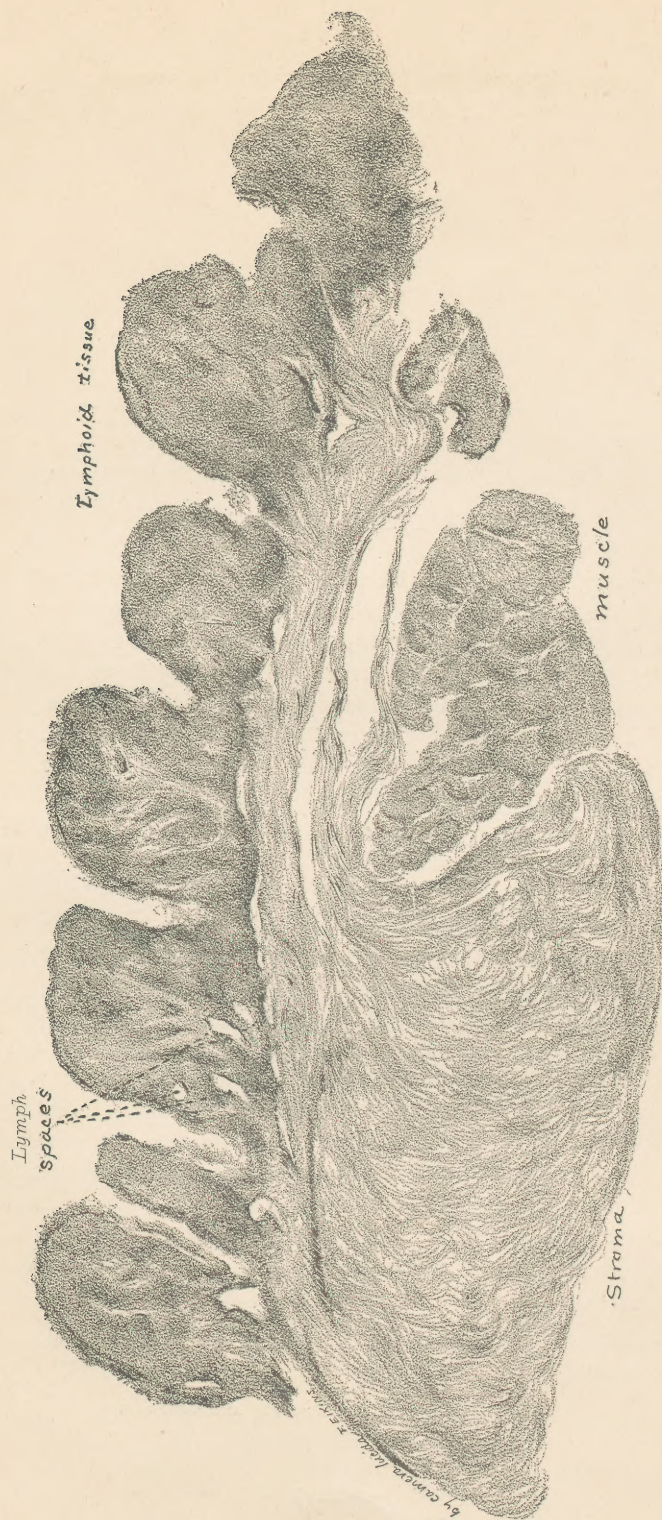


FIG. 1.—Mucous membrane from nasopharynx of newborn infant.

Six years ago I reported * a case of postnasal cyst. Unfortunately, the tissue removed was not examined microscopically. Since then I had not seen another case until last year, when one came to my class in the Out patient Department of Roosevelt Hospital, and was reported by Dr. Lamphear.† Microscopical examination in this case showed that the cyst cavity, as well as its external surface, was lined with pavement epithelium.

I may remark here that while normally the epithelium in the nasopharynx is columnar it shades off below into the squamous type, and in many cases of hypertrophied lymphoid growths, even in the vault, the covering is in part or wholly of squamous cells, evidently the result of irritation from secretions or rubbing surfaces. The cyst cavity in the case reported by Dr. Lamphear being lined with squamous epithelium, we may conjecture that the formation of the cavity by inclusion began subsequently to the metamorphosis of the epithelium. Dr. Lamphear says that with the exception of the report of my previous case, referred to above, there is no account of the condition in American journals. This pathological condition, then, it would seem, is of rare occurrence or rarely observed. I am under the impression that the case of cyst of the nasopharynx which I desire to bring to your notice in this paper is not, as were the others, in all probability, an inclusion cyst. Glandular cysts, I think, we can exclude. Glands are exceedingly scarce in the immediate vicinity of lymphoid tissue in the nasopharynx, and, when they are seen, show no tendency to cystic dilatation.

I desire to draw your attention for a moment to a section made transversely through the folds of the mucous membrane in the nasopharynx of a stillborn child, a drawing of which, under a very low power, is to be seen in Fig. 1. You see how sharply the lymphoid structures are separated from the underlying stroma. You also see how easily in the inflammation of infancy and childhood the distention and agglutination of these folds may give rise to sinuses and closed cavities, and the latter dilate into cysts by the accumulation of fluids from the lymphatics and blood-vessels. But there is in this section another point of interest which I believe has a more direct bearing upon the naso-pharyngeal case. Near the base of the folds may be seen oblong spaces, either just where the lymphoid tissue borders on the connective tissue, or just within the lymphoid tissue, or just within the connective tissue itself. Exam-

* A Cyst of the Pharyngeal Bursa. *Medical News*, September 7, 1889.

† A Cyst of the Pharyngeal Tonsil. *Med. Record*, August 4, 1894.

ining the walls of these spaces with a high power, it is seen that they are lined with a single layer, frequently not complete in this section, of very thin endothelial cells. These are evidently lymph



FIG. 2.—Naso-pharyngeal cyst.

spaces visible, because they are here not gorged with the round cells which crowd them elsewhere. Now it becomes evident that

retention cysts may originate from these spaces becoming closed cavities.

With these preliminary remarks I desire to report two cases—one of a cyst in the nasopharynx and one in the oropharynx:

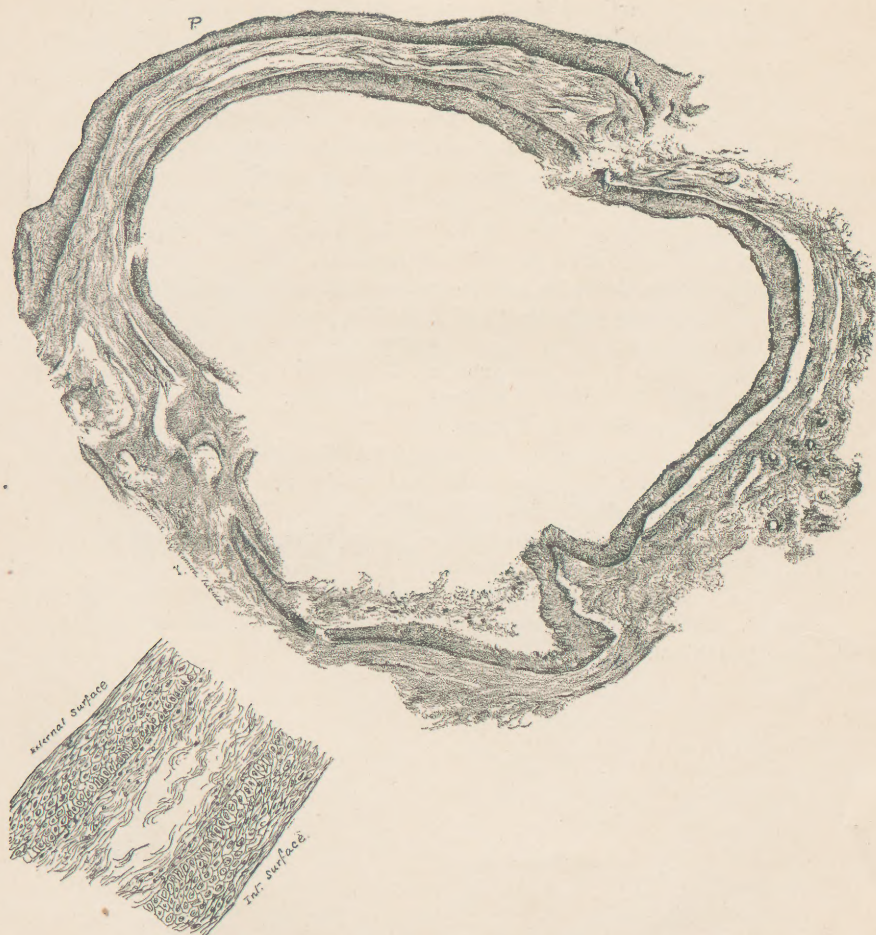


FIG. 3.—Oro-pharyngeal cyst. P, point from which high-power drawing is taken.

CASE I.—Last year a young colored woman was being treated at the dispensary for an ethmoid trouble, requiring removal of considerable portions of the ethmoidal turbinated bone. A round piece of tissue, about the size of a large pea, apparently lymphoid, was seen in the pharyngeal vault not far from the septum. Its presence apparently

gave rise to no symptoms, and there was no other lymphoid growth. It was removed with cutting forceps, and a section of it I show you in Fig. 2. Externally the surface is covered by typical columnar epithelium. A cyst cavity, as you see, occupies about one half a mass of lymphoid tissue. The cavity has no epithelial or endothelial lining at all, though it may have been destroyed by hardening in alcohol. Near one side of the large cavity, however, is an oblong space, such as is shown in Fig. 1. This also has no lining of cells. The absence of an epithelial lining in the cavity, while it is present on the surface, and the small size, would rather militate against a cyst by inclusion, while the absence of epithelial lining and of any other evidence of glands in the vicinity would tend to exclude a glandular origin. The cyst cavity measures three by four millimetres; the other spaces are scarcely visible to the naked eye. I am therefore inclined to think this a dilated lymph space, although I can not be sure of it.

CASE II was that of a middle-aged woman, with a family history of cancer, who came complaining of something growing in her throat for the last eighteen months. A small tumor, a trifle larger but of the same shape as in Case I, was seen growing at the base of the right posterior faucial pillar, the region of squamous epithelium. It was smooth and sessile. It was cut off by forceps.

Fig. 3 is a drawing of a section of it. You will observe that it is a cyst, and has thin fibrous walls lined inside and out with squamous epithelium. No glands and no lymphoid tissue. This, then, is probably an inclusion cyst, having its origin in some acute inflammatory condition of the mucous membrane.

The character of the contents of neither of these cysts was recognized. There was some amorphous material in Case I, and in Case II it was fluid and escaped.

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FRANK P. FOSTER, M. D.

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